



Optimizing Health and Performance

Melanie Dorion, AGNP-BC
1410 Rolkin Court #201
Charlottesville, VA 22911
Tel: 434-290-1210
Fax: 434-234-9843

SanaVi Health's Intake Form

Please have this form filled and sent to us at least 2 work days before your appointment.

email us a copy with your labs/testing at admin@sanavihealth.com or fax at 434-234-9843

For clinical management, it is very useful to gain a detailed history. The answers to these questions will allow us to develop an appropriate program specifically for you.

General Information

Date: Date of your appointment:

Name: Birth date:

Age:

Address

Main phone #: Other phone #:

E-mail address:

I will periodically send educational and update emails. Check this box if you do not wish to receive these emails (we will only use emails for appointment information and forms if you check this box)

checkbox

Occupation: Full-time Part-time Retired Unemployed

Living Situation: Alone Spouse Partner Friend(s) Parents Children Other

Status: Married Single Divorced Widowed Other

How did you hear about us?

Ad: Friend/Co-worker: Course/seminar: Physician/Healthcare practitioner: Article Other

Please share the name of who referred you so we can thank them for the referral:



HEALTH

Optimizing Health and Performance

Medical Status

General Health: Height _____ Weight _____ Ideal Weight _____

What was your height & weight at 25 years old if applicable? _____

Rate your general health: Excellent ____ Good ____ Fair ____ Poor ____

When during the day is your energy the best? _____ Worst? _____

Allergies and sensitivities (drugs, food, other – if a medication please list what type of reaction occurs):

List your health care providers:

Last time you saw your primary care provider and for what reason?

When was the last time you got blood work and for what reason?

Do you currently or have you used in the past the following? If yes, please indicate how often, how much, and how long have you been using:

Alcohol		Coffee	
Cortisone/prednisone		Hormones	
Sedatives		Antacids / Laxatives	



Optimizing Health and Performance

Current Medications (prescription and over the counter) continue on the back if more space is needed:

Name of Medication	Dosing (how many mcg, mg, etc per tablet or capsule)	How often

Current Supplements: Vitamins/minerals, Herbals and others:

Name of Supplement with Brand	Dosing (how many mcg, mg, etc per capsule or tablet)	How often

Past Medical Conditions

Childhood illnesses (please list): _____

- Asthma
- Diabetes
- Heart Trouble
- High Blood Pressure
- Clotting Disorders
- Kidney Trouble
- Varicose Veins
- Thrombosis
- Stroke
- Arthritis
- Back pain
- Fractures
- Chronic Fatigue
- Osteoporosis
- Scoliosis
- Fibromyalgia
- Breast cysts
- Thyroid disease
- Alcoholism
- Colitis/Crohn's
- Lyme disease
- Eating Disorder
- Anorexia
- Gallstones
- Liver disease
- Epilepsy
- Loss of teeth
- Rheumatoid arthritis
- Hyperparathyroidism
- Hormone disorders
- Other _____
- Cancer, breast
- Cancer, colon
- Cancer, uterus
- Cancer, ovaries
- Cancer, other _____

Pertinent details:

Surgery or major hospitalizations:

Surgery or reason for hospitalization	Year

Please list the most significantly stressful events in your life?

- 1) _____ Date: _____
- 2) _____ Date: _____
- 3) _____ Date: _____
- 4) _____ Date: _____
- 5) _____ Date: _____



HEALTH

Optimizing Health and Performance

Family History

Please list the ages, health problems and if deceased, cause of death:

	Problem	Alive/deceased	Cause of death if applicable
Mother			
Father			
Brothers			
Sisters			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Do you have any blood relative such as aunt, uncle, cousins who have/had any of the following?

allergies	arthritis	asthma	cancer	diabetes
anemia	depression	skin disease	heart attack	genetic conditions
high blood pressure	stroke	ulcers	cataracts	thyroid
high cholesterol	seizures	sickle cells	mental health conditions	autoimmune conditions
hypoglycemia	Alzheimer's	blood disorders	dementia	
Lyme disease	other			



Optimizing Health and Performance

Personal History - Please use this page to type or write clearly a personal timeline/summary of symptoms and treatments you've tried.

Please use bullets to organize things and include the following:

Onset: when did this concern start/begin, when did it get worse

Location of pain/discomfort in the body if applicable

If symptom comes and goes, how long does it last

Things that make it better or treatments that have helped

Things that make it worse and treatments that have not helped



HEALTH

Optimizing Health and Performance

Medical Symptom Questionnaire (MSQ)

reproduced and modified from the Institute for Functional Medicine

Rate each of the following symptoms based on your typical health profile for the past 14 days (we want to know current symptoms, not past symptoms from 6 mo ago).

Point Scale

- 0 – **Never or almost never** have the symptom
- 1 – **Occasionally** have it, effect is **not severe**
- 2 – **Occasionally** have it, effect is **severe**
- 3 – **Frequently have it, effect is not severe**
- 4 – **Frequently have it, effect is severe**

Please remember this applies for the last 14 days

Head

- _____ Headaches
 - _____ Faintness
 - _____ Dizziness
 - _____ Insomnia
- Total** _____

Eyes

- _____ Watery or itchy eyes
 - _____ Swollen, reddened or sticky eyelids
 - _____ Bags or dark circles under eyes
 - _____ Blurred or tunnel vision (*Does not include near or far-sightedness*)
- Total** _____

Ears

- _____ Itchy ears
 - _____ Earaches, ear infections
 - _____ Drainage from ear
 - _____ Ringing in ears, hearing loss
- Total** _____

Nose

- _____ Stuffy nose
 - _____ Sinus problems
 - _____ Hay fever
 - _____ Sneezing attacks
 - _____ Excessive mucus formation
- Total** _____

Mouth/Throat

- _____ Chronic coughing
 - _____ Gagging, frequent need to clear throat
 - _____ Sore throat, hoarseness, loss of voice
 - _____ Swollen or discolored tongue, gums, lips
 - _____ Canker sores
- Total** _____



HEALTH

Optimizing Health and Performance

- 0 – **Never or almost never** have the symptom
- 1 – **Occasionally** have it, effect is **not severe**
- 2 – **Occasionally** have it, effect is **severe**
- 3 – **Frequently have it, effect is not severe**
- 4 – **Frequently have it, effect is severe**

Skin

- _____ Acne
- _____ Hives, rashes, dry skin
- _____ Hair loss
- _____ Flushing, hot flashes
- _____ Excessive sweating
- _____ Lack of sweating/inability to sweat **Total** _____

Heart

- _____ Irregular or skipped heartbeat
- _____ Rapid or pounding heartbeat
- _____ Chest pain **Total** _____

Lungs

- _____ Chest congestion
- _____ Asthma, bronchitis
- _____ Shortness of breath
- _____ Difficulty breathing **Total** _____

Kidney & Bladder

- _____ Recurrent bladder infections
- _____ Burning sensation during urination
- _____ Urine has a strong odor
- _____ Difficulty starting or stopping urination **Total** _____

Digestion

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloating feeling
- _____ Belching, passing gas
- _____ Heartburn
- _____ Intestinal/stomach pain **Total** _____

Other digestive questions - do not use to add up in the total

Have you traveled outside the U.S. in the last 5 years? **(yes/no)**

Have you ever lived outside the U.S.? where? _____

How many bowel movements do you have in a week? _____



HEALTH

Optimizing Health and Performance

- 0 – **Never or almost never** have the symptom
- 1 – **Occasionally** have it, effect is **not severe**
- 2 – **Occasionally** have it, effect is **severe**
- 3 – **Frequently have it, effect is not severe**
- 4 – **Frequently have it, effect is severe**

Joint/muscle

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness or limitation of movement
- _____ Pain or aches in muscles
- _____ Feeling of weakness or tiredness **Total** _____

Weight

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Compulsive eating
- _____ Water retention
- _____ Underweight **Total** _____

Energy/Activity

- _____ Fatigue, sluggishness
- _____ Apathy, lethargy
- _____ Hyperactivity
- _____ Poor sleep or insomnia
- _____ Restlessness **Total** _____

Mind

- _____ Poor memory or have "brain fog"
- _____ Confusion, poor comprehension
- _____ Poor concentration
- _____ Poor physical coordination
- _____ Difficulty in making decisions
- _____ Stuttering or stammering
- _____ Slurred speech
- _____ Learning disabilities **Total** _____

Emotions

- _____ Mood swings
- _____ Anxiety, fear, nervousness
- _____ Anger, irritability, aggressiveness
- _____ Depression **Total** _____

Other

- _____ Frequent illness
- _____ Frequent, urgent urination or painful bladder
- _____ Numbing and tingling in extremities **Total** _____

Grand Total _____

Fatigue - Adrenal Dysfunction Screening

Check with  only ones that apply

	Are you tired/fatigued almost every day, especially in the afternoon?
	Do you have a hard time falling asleep at night or have insomnia?
	Do you wake up frequently during the night?
	Do you have a hard time waking up in the morning early, or feeling refreshed?
	Do bright lights bother you more than they should?
	Do you startle easily due to noise or does noise bother you more than it bothers others?
	Do you take things too seriously, and are easily defensive/irritable?
	Do you feel you don't cope well with certain people or events in your life or get stressed very easily?
	Do you get panic attacks (heart racing, dry mouth, sweating, nausea, light headedness, feel out of breath, trembling, feel out of control)?
	Do you feel down/depressed or have been diagnosed with depression?
	Do you often get sick, more than most people?
	Are you exhausted for days after a very busy period of time, high stress, traveling that includes jet lag?
	Do you crave salt or salty foods?
	Do you often get dizzy/lightheaded when you get up quickly? Or have been told you have low blood pressure?
	Cannot tolerate exercising like you used to or get a lot more fatigued during and after exercise?
	Has your appetite decreased and have you lost weight without trying in the last few months?
	Are you sensitive to opioid pain and sedative medications?
	Do you experience "low blood sugars" or sugar cravings?
	Do you find you need more and more caffeine every day then you did in the past?
	Do you have allergies (environmental, cat/dog, etc)?

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention. Your total score is based on a scale of 0 to 24. **When you finish the test, add up the values of your responses.**

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations if given the opportunity? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

No chance of dozing = 0

Slight chance of dozing = 1

Moderate chance of dozing = 2

High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score	

Interpretation:

0: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

This printed version of the Epworth Sleepiness Scale is provided courtesy of Talk About Sleep, Inc. www.talkaboutsleepp.com.



HEALTH

Optimizing Health and Performance

Toxin Exposure Screening

One point for every mark. Add points at the bottom	Yes	No
Living/work/school Environment		
Are you often exposed to chemicals such as adhesives, paints/varnishes/solvents, welding/soldering materials or other air borne chemicals?		
Does your home or workplace have visible mold, water damage, damp windows, or basement or crawlspaces? Or had to be remediated for mold at any point?		
Have you ever been exposed to known heavy metals including mercury (broken mercury thermometers) or lead (lead paint or dust)?		
Does your home or workplace have cracking paint or decaying insulation or foam?		
Have you lived in a very old or brand new home?		
Do you frequently use "regular" cleaning products, disinfectants, hand sanitizers, air fresheners		
Are you frequently exposed to pesticides, fungicides or insecticides?		
Do you live or work near a cell phone tower, power lines or feel poorly when around these including Wi-Fi?		
Diet		
Do you consume conventionally grown (non-organic) produce?		
Do you consume conventionally raised (non free-range or non-organic) animal products?		
Do you consume fast foods 2+ times per week?		
Do you consume sodas or sports drinks 2+ times per week?		
Do you drink water from a well, spring or from plumbing installed before 1986?		
Others		
Do you smoke or are/have been exposed to second hand smoke?		
Have you had a root canal		
Are you chemically sensitive – feel irritated around smoke, perfumes, gasoline or regular cleaning products?		
Total		



HEALTH

Optimizing Health and Performance

Personal Habits & Nourishment

What do you enjoy most in your life currently? _____

What are your main interests and hobbies? _____

What do you worry about most in life? _____

Do you exercise? If so what kind? _____

Do you have a religious or spiritual practice ? If yes, please describe

Have you suffered from childhood trauma or adult trauma? If yes, what has soothed you the most in your healing.

Do you feel supported in your healing options and community? _____

What do you use for your drinking water? (**bottled, filtered, or tap water, well**) and how many oz water per day?

Other beverages: What kind ? And how much? _____

Do you normally feel warmer or cooler compared to others? (**cool or avg. or warm**)

If you are working, do you enjoy it ? _____ Do you take vacations? _____

Are you currently in a satisfying relationship? _____